STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295075	A. BUILDING _____ B. WING _____	03/13/2009

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification survey conducted at your facility from March 10, 2009 through March 13, 2009, in accordance with 42 CFR Chapter IV Part 483 - Requirements for States and Long Term Care Facilities. The census at the beginning of the survey was 64. The sample size was 15 including 2 closed records. The findings of the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	F 000	**DISCLAIMER CLAUSE** **PREPARATION AND/ OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.**	
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an investigation and resolution of lost or stolen items for 1 un-sampled resident (#16). Findings include: On 3/12/09 at 10 AM, an alert, verbal un-sampled male resident and his wife reported a letter from the resident's son (out of state) and a 200-minute	F 166		

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BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 4-10-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 telephone card were missing from the resident's bed-stand. The resident and wife indicated, due to the difficulty the son had trying to call on weekends into the facility (the facility did not answer), the son sent his father a phone card so the resident could call his son. They reported the card went missing approximately 6 weeks ago (the wife reported the son would remember the actual date). They indicated they reported the missing 200 minute telephone card to Activities Personnel and they filled out an "I Am A Missing Item" form. The resident's wife reported they were told the facility would look for the missing items and had not received any further information. The resident missed reading the son's letter and having the ability to talk with his son on the telephone. On 3/13/09 in the morning, the Administrator reported the Social Worker (SW) would handle the grievances. The Administrator reported the SW was on vacation and reportedly looked in the SW's office for the follow-up on the incident and was unable to find anything. The Administrator reported he remembered the incident however, he was unable to recall the follow-up or findings. The Administrator reported the instructions for handling grievances was written on an "I Am A Missing Item" form and was addressed in an "Admission Agreement." The Administrator reported the facility did not have a separate policy on grievances. The "Admission Agreements Section 12: Facility's Grievance Procedure" (dated 11/05), page 18 stated: "Reporting Complaints - The Resident	F 166	**F166 SS=D** a. Resident #16 Follow-up completed by Social Services on 3/23/09. b. Review of current missing items forms for resolution and completion. c. Staff in-service on missing items forms and process. d. Random audits to monitor compliance. Tract and trend in CQI. e. Executive Director responsible. f. To be completed on 4/10/09	04/10/09

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F 166	Continued From page 2	F 166		

has the right to express grievance without discrimination or reprisal. If Resident or Resident's Authorized Representative believe(s) that Resident is being mistreated or Resident's rights have been or are being violated by staff or another resident, Resident or Resident's Authorized Representative will make their concerns known to the Facility's Director of Nursing Services and/or Executive Director.

The facility will promptly review and investigate the concern and provide a timely response to Resident, Resident's Authorized Representative in accordance with our grievance procedure. The Resident has the right to contact state representatives concerning grievances. The names and addresses of these representatives are attached."

The "I Am A Missing Item" form stated: "We will look for the item for 2 weeks and will notify the family/resident of the final outcome. If it is not found we will continue to search for 30 days, after that, this form will be placed in the "Un-Found" file. All personal items Must be listed on the Inventory of Personal Possessions Form and marked legibly. Any item you bring in/take out must also be recorded on the Form."

Below the disclaimer on the "I Am A Missing Item" form was a section that marked:
- if the item was found
- if the family was satisfied and a place for their signature
- if the person wasn't satisfied with the results a meeting with the Administrator and the date the meeting occurred was to be recorded
- the outcome
- review dates by the Administrator, Maintenance

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F 166	Continued From page 3 and the Social Worker. The Administrator was unable to find the "I Am A Missing Item" form the family previously completed and the facility lacked documented evidence of resolution to the missing items reported.	F 166		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents' rights regarding physical restraints for 2 of 15 residents (#13, #12). Findings include: Resident #13 Resident #13 was admitted on 7/24/07 with diagnoses including Debility, Dislocated Shoulder, Rheumatoid Arthritis, Chronic Ischemic Heart Disease, Cholelithiasis, Aortic Aneurysm, Alzheimer's Disease, Urinary Tract Infection, and Chronic Airway Obstruction. The Interdisciplinary Team Conference (IDT) dated 2/11/09, listed the following under the "Restraints" section: "alarming wheelchair cushion; wedge; PVC (plastic) low bed; scoop mattress; bed alarm; and mats to floor." The previous IDT conferences listed nothing in the	F 221	F221 SS=D a. Resident #12 and #13 care plans, consents updated to address devices. IDT notes adjusted to reflect devices used. b. Chart audit of resident's with devices for updating. c. Random audits to monitor compliance. Track and Trend in CQI. d. DNS responsible. e. To be completed on 5/4/09	05/04/09

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F 221	Continued From page 4 "restraint" section. No physician's orders were provided for the "restraints." "Physical Restraint/Device Consents" were documented in the file as follows: - PVC low bed, dated 11/29/08. The "is the device considered a restraint for this resident" section was checked "no" and the "why" section was documented as "to prevent injury if roll out of bed." - Alarming Wheelchair Cushion, dated 12/15/08. The "is the device considered a restraint for this resident" section was checked "no" and the "why" section was documented as "still able to have freedom of movement." The "reason for use" section was documented as "to alert staff trying to self transfer without assistance." - Scoop pressure reducing mattress, dated 11/29/08. The "is the device considered a restraint for this resident" section was checked "no" and the "why" section was documented as "to define edge of mattress." - Wedge cushion in wheelchair with Dycem to prevent slipping, dated 11/29/08. The "is the device considered a restraint for this resident" section was checked "no" and the "why" section was blank. - Bed Alarm - Mats to floor, dated 11/29/08. The "is the device considered a restraint for this resident" section was checked "no" and the "why" section was blank. The "reason for use" section was documented as "to alert staff trying to self	F 221		

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F 221	Continued From page 5 transfer without assistance." Resident #12 Resident #12 was admitted on 7/24/07 with diagnoses including Anoxic Brain Damage, Muscle Disuse Atrophy, Muscle/Ligament Disorder, Nausea, Convulsions, Developmental Delays, and Debility. A physician's order was written on 11/1/2004 for "padded side rails x 2 (both) for seizure precautions." The Interdisciplinary Team Conference (IDT) dated 2/11/09 listed the following under the "Restraints" section: "side rails padded up times 2, shoulder harness, reclining wheelchair, Hoyer lift, helmet." No current physician's orders were available addressing a shoulder harness, reclining wheelchair, Hoyer lift, and helmet. A "Physical Restraint/Device Consent" (signed 12/3/08) listed the Restraint as "Reclining Wheelchair/ shoulder harness/helmet/ siderails up times 2." The "is the device considered a restraint for this resident" section was checked "no" and the "why" section stated "enables him to get out of bed." On 3/13/09 at 10 AM, the Director of Nursing (DON) was interviewed. The DON indicated (in reference to the side rail use as the consent rationale stated) the resident would be unable to get out of bed, with or without side rails. The DON confirmed the rationale was incorrect.	F 221		
F 222	483.13(a) CHEMICAL RESTRAINTS	F 222		

TEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 222 SS=D	Continued From page 6 The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure behavior monitoring for medications were adequate for 1 of 15 residents (#3). Findings include: Resident #3 Resident #3 was admitted on 2/12/06 with diagnoses including Multiple Sclerosis, Chronic Airway Obstruction, Spasm of Muscle, Insomnia, Glaucoma, Esophageal Reflux, and Pneumonia. A physician's order dated 2/22/06, was written for "Zoloft 50 mg (milligrams), 1 tab po (orally) for Depression. Monitor behavior frequency of occurrence by tally hatchmark." The care plan did not identify what behaviors were to be monitored. On 3/11/09 in the afternoon, via interview, the Minimum Data Set (MDS) Coordinator/Care Plan Manager was unable to describe the the behaviors the nursing staff was to be monitoring and tallying. On 3/13/09 in the morning, via interview, the Director of Nursing (DON) indicated the behavior	F 222	F-222 SS=D a. Resident #3 behaviors were identified and addressed on Care plan and on MAR. b. Chart audit for presence of Antidepressant behaviors and updating. c. Random audits for compliance. Track and trend in CQI. d. DNS responsible e. To be completed on 5/4/09	05/04/09

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F 222	Continued From page 7 to be monitored was "crying." The Medication Administration Record (MAR) did not list which behavior was to be monitored. The MARs (from 9/08 to 3/09) indicated "0" in the behavior tally column for all dates except 12/1/08.	F 222		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to ensure the comprehensive care plans were followed and updated to reflect the resident's current plan of care for 3 of 15 residents (#3, #8, #10).	F 279	F-279 SS=D a. Residents #3 had the Care Plan discontinued and removed from the chart. Resident #10 Care Plan and MAR were updated to address behaviors Resident #10 treatment sheet and Care Plan updated to reflect dialysis site and documentation requirements. b. Current resident's on Dialysis treatment sheets and Care Plans will be reviewed and updated. c. Staff in-service on Dialysis documentation. d. DNS responsible e. to be completed 5/4/09.	05/04/09

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F 279	Continued From page 8 Findings include: Resident #3 Resident #3 was admitted on 2/12/06 with diagnoses including Multiple Sclerosis, Chronic Airway Obstruction, Spasm of Muscle, Insomnia, Glaucoma, Esophageal Reflux, and Pneumonia. Restoril was on the Care Plan, originally dated 9/25/08. The care plan indicated the Restoril was reviewed on 12/12/08 and on 3/5/09. There was no indication on the care plan the Restoril was discontinued. The resident's Restoril was "discontinued on 12/20/09." The Director of Nursing indicated the date should have been 12/20/08. Resident #8 Resident #8 was admitted on 11/14/05 with diagnoses including Hypertension, Renal and Ureteral Disorder, Rotator Cuff, Malaise and Fatigue, Debility, Dementia without Behavior, and Presenile Depression. A physician's order was written 9/22/08 for "Xanax 0.25 mg (milligram) PRN (as needed) for anxiety. monitor number of behaviors." A 10/5/08 entry documented "Xanax .25mg twice daily." The twice daily was not crossed out, and above it was written "3x's day." A 12/11/08 6:30 PM Nurse's Notes entry stated "Left message on Dr. ... phone regarding increase Xanax 0.25 to TID (3 times per day) per residents and family request."	F 279		

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F 279	Continued From page 9 On 12/20/08 the Xanax was increased to 0.25mg TID. Xanax was care planned beginning 9/6/08 and was documented as reviewed on 11/26/08 and 2/12/09. The care plan did not address the behaviors to be monitored. Resident #10 Resident # 10 was a 70 year old male admitted to the facility on 1/6/09 with diagnoses including Renal Failure, Fracture Hip, Hypertension Coronary Atherosclerosis, and Diabetes. The resident's care plan interventions dated 1/8/09, indicated: - "Dialysis days - Monday, Wednesday and Friday - Send a copy of the current MAR (Medication Administration Record) and or Dialysis Transfer Sheet with resident to Dialysis - Obtain information from Dialysis center upon resident return to facility - If information not received from Dialysis Center with weights, proceed with facility procedure for obtaining weights" Documentation in the nurse's notes dated 2/18/09 revealed: -"...Goes to dialysis 3x(times) wk (week)..." -"...No s/s (signs or symptoms) infection to shunt site" -"...Able to palpate thrill and bruit" The facility lacked documented evidence in the medical record of: - observation for s/s of infection at the dialysis site	F 279		

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F 279	Continued From page 10 on any other day - assessment of the patency of the shunt on any other day - communication with dialysis - monitoring of weights before and after dialysis The facility policy titled - Dialysis, Dated June 2004 indicated: Procedure: 8. The facility: a. "Ensures the dialysis center develops a dialysis treatment plan" b. "Incorporates this treatment plan into the resident's comprehensive plan of care..." e. "Provides ongoing monitoring of the dialysis access site, observing for signs and symptoms of infection, edema, ischemia, bleeding and dislodgement" f. "Utilizes a dialysis flow sheet to document the specific of the resident's dialysis care. The folw sheet includes the monitoring of catheter and the Fistula or Graft." On 3/12/09 in the afternoon, the Director of Nurses (DON) confirmed that the dialysis access, weights and communication with the dialysis center were not documented in Resident #10's record.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents maintained the highest physical well being and that physician's orders were followed for 4 of 15 residents (#3, #12, #10, #1). Findings include: Resident #3 Resident #3 was admitted on 2/12/06 with diagnoses including Multiple Sclerosis, Chronic Airway Obstruction, Spasm of Muscle, Insomnia, Glaucoma, Esophageal Reflux, and Pneumonia. A physicians's order was written on 11/12/08 for Restorative Nursing Program; standing in "Standing Frame" 4 times per week. - The November 2008 "Restorative Flow Sheet" indicated the following procedures were to be completed: Range of Motion (ROM) bilateral lower extremities (BLE); back stretches; Standing Frame and Tossing Ball. Services were documented as received as ordered through the 23rd of November 2008. From 11/24/08 through 11/31/08 services were provided on the 25th, 28th and 29th. - The December 2008 "Restorative Flow Sheet" indicated the following procedures were completed: ROM BLE; back stretches; and Standing Frame. Services were documented as received as	F 309	F-309 SS=D a. Resident #1 is no longer in the facility. Resident # 3 is no longer receiving RNA services, currently on therapy caseload. Resident #10 Care Plan and treatment sheet are updated. Resident #11 is no longer in the facility. b. Resident with pending consults were addressed. c. In addition to Staff meeting there will be a meeting with ordering physicians, DNS and Executive Director. d. Random monitoring of consults. Tract and Trend in CQI. e. DNS is responsible f. To be completed by 5/4/09	05/04/09

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F 309	Continued From page 12 ordered through the 6th. From 12/7/08 through 12/31/08 services were provided on the 10th, 11th, 17th, 18th, 23rd, 24th, 25th, 27th and 31st. - The January 2009 "Restorative Flow Sheet" indicated the following procedures were to be completed: ROM BLE; back stretches; and Standing Frame. Services for ROM and Back Stretches were provided on the 3rd, 4th, 9th, 10th, 11th, 12th, 16th, 17th, 23rd, 25th, and 26th. Services for Standing Frame were documented as received on the 26th. - The February 2009 "Restorative Flow Sheet" indicated the following procedures were to be completed: ROM BLE; back stretches; and Standing Frame. Services for ROM and Back Stretches were provided on the 6th, 7th, 8th, 9th, 16th, 17th, 20th, 21st, 22nd, and 27th. Services for Standing Frame were documented as received on the 7th, 16th, 17th and 21st. - The March 2009 "Restorative Flow Sheet" indicated the following procedures were to be completed: ROM; and Standing Frame. No services were documented as received. Resident #12 Resident #12 was admitted on 11/1/04 with	F 309		

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F 309	Continued From page 13 diagnoses including: Anoxic Brain Damage, Muscle Disuse Atrophy, Muscle/Ligament Disorder, Nausea, Convulsions, Developmental Delays, and Debility. The February 2009 Recapitulation orders did not include an order for the "Restorative Nursing Program." The Resident's record contained documented evidence he was receiving restorative services as follows: - The December 2008 "Restorative Flow Sheet" indicated the following procedures were to be completed: Range of Motion (ROM) bilateral upper extremities (BUE) 5 x's weekly; Lower extremities exercises 20 repetitions with 2 pound (lbs) weights; Standing Frame 6 times weekly; and Shoulder Flex/Extend. Services were documented as received on the 4th, 5th, 11th, 12th, 13th, 15th, 16th, 19th, 29th, 21st, 22nd 23rd and 28th. - The January 2009 "Restorative Flow Sheet" indicated the following procedures were to be completed: Range of Motion (ROM) bilateral upper extremities (BUE) 20 times (xs) 2 lbs.; ROM Lower extremities (LE) exercises 20 xs with 2 lbs weights; and Standing Frame. Services for the ROM exercises were documented as received on the 4th, 9th, 10th, 11th and 16th. The Standing Frame section contained no documented evidence services were received.	F 309		

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	295075	A. BUILDING _____ B. WING _____	03/13/2009

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F 309	Continued From page 14 - The February 2009 "Restorative Flow Sheet" indicated the following procedures were to be completed: Range of Motion (ROM) bilateral upper extremities (BUE) 20 times (xs) 2 lbs.; ROM Lower extremities (LE) exercises 20 xs with 2 lbs weights; and Standing Frame. Services for the ROM exercises were documented as received on the 8th, 9th, 14th, 16th and 27th. The Standing Frame section contained no documented evidence services were received. Resident #10 Resident # 10 was a 70 year old male admitted to the facility on 1/6/09 with diagnoses including Renal Failure, Fracture Hip, Hypertension Coronary Atherosclerosis, and Diabetes. The facility's Charting Guidelines: Renal Failure/Dialysis dated 9/07, which was located in Resident#10's medical record indicated: -"Daily Weights as ordered or weights from dialysis" - "Monitor shunt/fistula site daily" - "Assess patency of shunt/fistula/permacath graft by palpating for a thrill or auscultate for a bruit" The resident's care plan interventions dated 1/8/09, indicated: - "Dialysis days - Monday, Wednesday and Friday - Send a copy of the current MAR and or Dialysis Transfer Sheet with resident to Dialysis - Obtain information from Dialysis center upon resident return to facility - If information not received from Dialysis Center with weights, proceed with facility procedure for	F 309		

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F 309	Continued From page 15 obtaining weights" Documentation in the nurse's notes dated 2/18/09, revealed: -"...Goes to dialysis 3x(times) wk (week)..." -"...No s/s (signs or symptoms) infection to shunt site" -"...Able to palpate thrill and bruit" The facility lacked documented evidence in the medical record of: - observation for s/s of infection at the dialysis site on any other day - assessment of the patency of the shunt on any other day - communication with dialysis - monitoring of weights before and after dialysis The facility policy titled - Dialysis, Dated June 2004 indicated: Procedure: 8. The facility: a. "Ensures the dialysis center develops a dialysis treatment plan" b. "Incorporates this treatment plan into the resident's comprehensive plan of care..." e. "Provides ongoing monitoring of the dialysis access site, observing for signs and symptoms of infection, edema, ischemia, bleeding and dislodgement" f. "Utilizes a dialysis flow sheet to document the specific of the resident's dialysis care. The flow sheet includes the monitoring of catheter and the Fistula or Graft." On 3/12/09 in the afternoon, the Director of Nurses (DON) confirmed that the dialysis access, weights and communication with the dialysis center were not documented in Resident #10's	F 309		

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F 309	Continued From page 16 record. Resident #1 Resident #1 was an 80 year old female admitted to the facility on 12/17/08 with diagnoses including Diabetes, Hypertension, Coronary Artery Disease and Urinary Tract Infections. The Bowel and Bladder Assessment dated 12/17/08 documented: - Foley catheter in place. - Resident has a UTI (urinary tract infection). Nurse's notes revealed the following: - 12/19/08 - Foley catheter discontinued. - 1/26/09 - "c/o (complaining of) difficulty voiding, burning on urination. Straight cath done." - 2/1/09 - "Resident c/o severe bladder pain 10/10...Lab results reported to doctor related to U/A (urinalysis). Received order for Cipro (Ciprofloxacin) 500 mg po (by mouth) bid (twice a day) x (for) 3 days." 2/15/09 1350 (1:50 PM) "...Resident c/o (complaining of) urinary retention... She was unable to void." 1400 (2:00 PM) "...abdomen was observed to be distended and hard.." 1440 (2:40 PM) "Resident transported to hospital." 2200 (10:00 PM) "Resident returned from Desert View Hospital. Dx (Diagnosis) with UTI. Cipro ordered." Results of urine culture and sensitivity (C&S) dated 12/29/08 revealed: Culture - 50-100,000 Colonies/ml Escherichia Coli (E-Coli) Resistant - Ciprofloxacin	F 309		

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F 309	Continued From page 17 Results of urine culture and sensitivity dated 3/3/09 revealed: Culture Results - >100,000 Colonies/ml Escherichia Coli Resistant - Ciprofloxacin Normal Value for urine C&S - No growth There were no additional urine C&S results available on the chart. Resident #1's Medication Administration Record MAR revealed Cipro was given for the UTI as follows: Cipro 250 mg po daily x 3 days - 1/1/09, 1/2/09 and 1/3/09; Cipro 500 mg po bid x 5 days - 2/16/09 - 2/20/09; Cipro 500 mg po on 3/4/09 and 3/5/09 Physician's order dated 3/5/09 indicated: "D/C (discontinue) Cipro 500 mg; Bactrim DS 1 tab (tablet) po bid x 7 days (for UTI)" On 3/11/09 in the afternoon, the unit manager confirmed the urine C&S results on the chart revealed the organism causing the resident's UTI, E-Coli, was resistant to Cipro. Resident #11 Resident #11 was a 67 year old female admitted to the facility on 11/10/08 with diagnoses including Dehydration, Polio, L side weakness, Bronchitis and Urinary Tract Infections. Resident had a gastrostomy tube and received Tube Feedings of Fibersource 50 cc/hour.	F 309		

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F 309	Continued From page 18 Physician Progress Notes dated 2/18/09 indicated "She has a large Incisional Hernia which the nurses believe is hurting her. Will ask Dr... to evaluate." Physician's order dated 2/18/09 revealed: "Surgical Consult to Dr...." Nurses notes revealed: -2/19/09 ".. Swelling noted a few inches below G-tube stoma..." "...left message for MD re: s/s of infection and surgical consult order." "...order received for Keflex...He (MD) is out of town and evaluate when he returns." Resident #11's Medication Administartion Record (MAR) for February and March 2009 indicated pain medication was given as follows: Hydrocodone 5/500 mg 1 tab for moderate pain on 2/19, 2/20, 2/21, and 3/12/09 Hydrocodone 5/500 mg 2 tabs for severe pain on 3/9/09. On 3/11/09 in the afternoon Resident #11 was lying in bed in her room, crying. Her mother was in the room with her. The resident's mother stated Resident #11 had severe abdominal pain." On 3/12/09 in the afternoon, resident was observed lying in bed. She stated she was having severe abdominal pain. On 3/12/09 in the afternoon, the RN (Registered Nurse) stated that Resident #11 frequently had abdominal pain due to constipation. The resident had not moved her bowels in several days and had received medication to assist with a bowel movement. The RN also confirmed that Resident	F 309		

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F 309	Continued From page 19 #11 had not received the surgical consultation yet. She also stated she did not know when this would be done. There was no documented evidence that the surgical consult was performed	F 309		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents did not receive unnecessary medications for 2 of 15 residents	F 329	F-329 SS=D a. Resident #11 is no longer in the facility. Resident #10 admitted on Lovenox s/p Fx of hip. Resident was changed to Atrixia due to non-healing fracture delaying full weight bearing status until 4/1/09. Medicatin discontinued. b. Review of resident's on injectable anticoagulants for d/c date. c. Staff education. d. Random audits and Track and Trend in CQI. e. DNS is responsible. f. To be completed 5/4/09	05/04/09

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F 329	Continued From page 20 (#11, 10). Findings include: Resident #11 Resident #11 was a 67 year old female admitted to the facility on 11/10/08 with diagnoses including Dehydration, Polio, Left sided weakness, Bronchitis and Urinary Tract Infections. The resident had a gastrostomy tube and received Tube Feedings of Fibersource 50 cc/hour. Pharmacy review dated 12/16/08 indicated: "Resident currently rx'd (prescribed) with heparin 500 units SQ twice daily since 11/25 and prior to that was on Lovenox since admitted on 11/10/08. This now gives her a total of (approximately) 35 days of DVT (Deep Vein Thrombosis) prophylaxis just within this facility. Typical duration is usually limited to 7-10 days for acute illness/immobilization with a maximum of 35 days for higher risk patients. Recommend to discontinue heparin at this time." The physician acknowledged the pharmacist's recommendation on 1/2/09 and the Heparin was discontinued at that time. Resident #10 Resident # 10 was a 70 year old male admitted to the facility on 1/6/09 with diagnoses including Renal Failure, Fracture Hip, Hypertension Coronary Atherosclerosis, and Diabetes. Pharmacy review dated 1/22/09 included the the following recommendation to the physician:	F 329		

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F 329	Continued From page 21 -"Patient recently had emergent inguinal hernia repair and has a history of left hip fracture surgery. Per discharge summary, he was to continue on Lovenox x 10 more days. However, he is now admitted on Lovenox x 30 mg SQ (subcutaneously) daily without a stop date. He has received 14 days at this facility and stitches have been removed from hip. Recommend to discontinue Lovenox at this time." There was no physician response noted on the pharmacy recommendation form. The Medication Administration Record (MAR) revealed that Resident #10 continued to receive Lovenox 30 mg SQ daily until February 27, 2009, when the medication was discontinued.	F 329		
F 371 SS=B	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure food was stored, prepared and distributed under sanitary conditions. Findings include: 1. Refrigerator temperatures	F 371	F- 371 The refrigerator was serviced on 3/11/09. Temperatures are within range. Framing bars were treated and painted on 4/7/2009. Cart was removed from in front of sink. Hot water heater was replaced on 3/12/2009. Maintenance supervisor will monitor water temperatures weekly. Dietary manager will monitor refrigerator temperatures daily. ED will monitor at random and report to CQI.	03/11/09 4/07/09 3/10/09 3/12/09

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F 371	Continued From page 22 - On 3/10/09, at 8:30 AM, the larger refrigerator in the food preparation area had a temperature reading of 47 degrees Fahrenheit (F). - On 3/10/09, at 8:30 AM, the smaller refrigerator in the food preparation area had an outside thermometer temperature reading of 34 degrees F and an interior thermometer temperature reading of 44 degrees F. The Food Service Manager reported the refrigerators were open during the morning meal. - On 3/10/09, at 4:30 PM, the larger refrigerator in the food preparation area had an outside thermometer temperature reading of 48 degrees F and an interior thermometer temperature reading of 44 degrees F. - On 3/10/09, at 4:30 PM, the smaller refrigerator in the food preparation area had an outside thermometer temperature reading of 28 degrees F and an interior thermometer temperature reading of 40 degrees F. 2. The bars framing the walk-in freezer were rusted. 3. The hand wash sink in the kitchen was blocked by a cart. 4. Hot water was not available at the serving station sink.	F 371		
F 385 SS=D	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the	F 385		

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F 385	Continued From page 23 care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure appropriate physician supervision and follow up on resident's care for 2 of 15 residents (#10, #1). Findings include: Resident #10 Resident # 10 was a 70 year old male admitted to the facility on 1/6/09 with diagnoses including Renal Failure, Fracture Hip, Hypertension Coronary Atherosclerosis, and Diabetes. Pharmacy review dated 1/22/09 included the the following recommendation to the physician: -"... He has received 14 days at this facility and stitches have been removed from hip. Recommend to discontinue Lovenox at this time." There was no physician response noted on the pharmacy recommendation form. The Medication Administration Record (MAR) revealed that Resident #10 continued to receive Lovenox 30 mg SQ daily until February 27, 2009 when the medication was discontinued.	F 385	F- 385 SS=D a. Resident #1 is no longer in the facility. Resident #10, MD was contacted and medication addressed. b. Pharmacy recommendations reviewed for MD response and follow-up. c. Staff in-service and meeting with ordering physicians regarding pharmacy recommendations. d. Random audits and track and trend in CQI. e. DNS is responsible. f. To be completed by 5/4/09.	05/04/09

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F 385	Continued From page 24 Resident #1 Resident #1 was an 80 year old female admitted to the facility on 12/17/08 with diagnoses including Diabetes, Hypertension, Coronary Artery Disease and Urinary Tract Infections. Pharmacist recommendation to the physician dated 1/22/09 revealed: -"... Recommend to start Plavix 75 mg (milligram) daily for CAD prophylaxis." There was no physician response documented on the pharmacy recommendation form. There was no documented evidence that the pharmacy recommendations were acknowledged. There was no documented evidence on Resident #1's Medication Administration Record (MAR) dated January, February and March 2009 that Plavix or any other antiplatelet was ordered for CAD prophylaxis.	F 385		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 428		

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F 428	Continued From page 25 failed to act upon the pharmacist's recommendations identified during the monthly medication review in a timely manner for 2 of 15 residents (# 1, 5). Findings include: Resident #1 Resident #1 was an 80 year old female admitted to the facility on 12/17/08 with diagnoses including Diabetes, Hypertension, Coronary Artery Disease and Urinary Tract Infections. Pharmacist recommendation to the physician dated 1/22/09 revealed: -"Patient is an 80 year old female with T2DM (Type II Diabetes Mellitus) and a history of CAD (Coronary Artery Disease). She is allergic to aspirin therefore is not on any antiplatelet for CAD prophylaxis. Recommend to start Plavix 75 mg (milligram) daily for CAD prophylaxis." There was no physician response documented. There was no documented evidence that the pharmacy recommendations were acknowledged. There was no documented evidence on Resident #1's Medication Administration Record (MAR) dated January, February and March 2009 that Plavix or any other antiplatelet was ordered for CAD prophylaxis. Resident #5 Resident #5 was a 77 year old female readmitted to the facility on 12/8/08 with diagnoses including Diabetes, Pneumonia, and Debility.	F 428	F-428 SS=D a. Resident #1 is no longer in the facility. Resident #5 the medication was adjusted per recommendation on 3/18/09. b. Pharmacy recommendations for current Residents reviewed for follow-up. c. Staff in-service and meeting with ordering MD's. d. Random audit, track and trend in CQI. e. DNS is responsible. f. To be completed by 5/4/09.	05/04/09

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F 428	Continued From page 26 The pharmacist recommendation to physician dated 1/22/09 revealed: "Patient has an order for Senna Plus twice daily for constipation. However, she occasionally continues to have diarrhea and Imodium prn (when necessary) is given. She also continues on methotrexate, which may be causing some diarrhea. Recommend to reduce Senna Plus to one tablet daily." On 2/26/09, the physician signed that he agreed with the pharmacist's recommendation. Resident #5's Medication Administration Record (MAR) dated February 2009 and March 2009 revealed the resident continued to receive Senna Plus twice a day. There was no physician order written to change the medication. There was no telephone or verbal order written by the nursing staff to change the medication as suggested. Interview On 3/12/09 in the morning, the Director of Nursing (DON) stated the recommendations of the pharmacist are placed on the chart for the physician to review when the physician makes the next visit. If there was no response from the physician for one month, the pharmacist placed another recommendation form in the record. The physician would sign off and indicated if he agreed or disagreed with the recommendations and provided the rationale. Once the physician signed the form, the physician would write an order in the medical record when indicated.	F 428		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 27 If the physician indicated he agreed with the pharmacist recommendation and did not write an order, the nurse would write the telephone order in the record and initiate the changes. The DON also stated if the nursing staff had any questions regarding the physician orders, they should contact the physician to clarify the issue.	F 428		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure a sanitary environment for the prevention of infection control. Findings include: During the Initial Tour (3/10/09 at approximately 9 AM) room #503 was identified by the staff and by signage that it was an "Isolation Room." The staff conducting the tour reported the resident in the room had Clostridia Difficile (C-Diff).	F 441	F-441 SS=D a. Resident with Foley catheter in room #503 was addressed. b. Resident's currently in the facility with Foley catheters will be assessed for placement. c. Staff in-service. d. Random audits and track and trend in CQI. e. DNS is responsible. f. To be completed by 5/4/09	05/04/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295075	A. BUILDING _____ B. WING _____	03/13/2009

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F 441	Continued From page 28 A Foley catheter drainage bag was laying on the floor, next to the bed. Brown liquid was in a large puddle around the outside of the catheter drainage bag.	F 441		